



Professional Athlete Neurological Examination Report

This form is required for any combatants age 35 or older.

Only a licensed neurologist or neurosurgeon can conduct this examination and complete this form.
Please complete this form in its entirety.

Participant's Full Name _____
Last First Middle

HISTORY

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in Tennessee? [] Yes [] No

Please explain: _____

EXAMINATION:

CRANIAL NERVES:

1. Pupillary size in MM OD _____ OS _____ Reactivity OD _____ OS _____
Note any asymmetry _____ N/A _____
2. Fundus OD _____ OS _____ N/A _____
3. Eye closure _____ N/A _____
4. Extraocular motility visual pursuit _____ saccades _____ nystagmus _____
Describe any abnormality _____ N/A _____
5. Palate elevation _____ N/A _____

MOTOR:

6. Strength RUE _____ LUE _____ FILE _____ LLE _____ (0 – 5/5)
List any abnormality _____ N/A _____
7. Tone RUE _____ LUE _____ FILE _____ LLE _____
(I = increased D = decreased N = normal) N/A _____
8. Range of motion RUE _____ LUE _____ FILE _____ LLE _____
Describe reason for restriction _____ N/A _____
9. Abnormal movements (tics, chorea, choreiform, myoclonus, etc.) _____
Fasciculations _____
Describe any abnormal movements _____ N/A _____

CEREBELLAR:

10. Finger – nose – finger Describe any abnormalities _____ N/A _____
11. Heel – shin Describe any abnormalities _____ N/A _____
Abnormal = 3 failures
12. Rebound check Describe any abnormalities _____ N/A _____
Abnormal = 2 failures
13. Rapid alternating hand movements
Describe any abnormalities _____ N/A _____
14. One foot hop (3 trails, 5 secs ea ft)
Describe any abnormalities _____ N/A _____
15. Romberg Describe any abnormalities _____ N/A _____

GAIT:

16. Gait
Routine Gait _____ Heal Walk _____ Toe Walk _____ Tandem Walk _____
Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)
_____ N/A _____

SENSATION:

17. Sensation _____ N/A _____

DEEP TENDON REFLEXES:

18. Deep Tendon Reflexes _____ N/A _____

19. Babinski _____ N/A _____

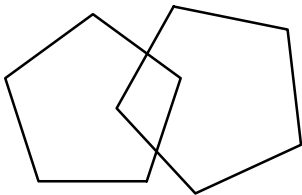
OTHER OBSERVATIONS (20)

20. List any other symptoms or evidence of neurological abnormalities from history or observations.

MENTAL STATUS EXAMINATION:

MINI-MENTAL STATUS EXAM

	Maximum Score	Score
1. What is the (year) (season) (date) (month)	5	_____
2. Where are we (state) (county) (city) (hospital) (floor)	5	_____
3. Name 3 objects: (e.g., cow, apple, bus) – one second to say each Then ask applicant all three after you have said them. (One point for each correct answer.) Then repeat them until he/she learns all 3. Count trials and record. Trials = _____	3	_____
4. Serial 7's. (One point for each correct.) Stop after 5 attempts	5	_____
5. Ask for the 3 objects repeated above (one point for each correct)	3	_____
6. Name a pencil and a watch	2	_____
7. Repeat: "NO IFS, ANDS, OR BUTS"	1	_____
8. Follow a 3-stage command: 'TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9. Copy Design	1	_____



Total Score _____
(0-21 suggestions cognitive impairment)

EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? [] Yes [] No

If no, please explain:

Licensed Physician's Name (print)

Medical License No.

Applicant Name (print)

Address/ City/ State/ Zip Code

Applicant Signature

Physician's Signature

Date/ Time

Authorization to Use and Disclose Protected Health Information

I hereby authorize _____ (Physician) to furnish to the Tennessee State Athletic Commission (the "Commission"), or its successors, copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by the Commission in connection with my application for licensure by the Commission or any further or future investigation by the Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose.

I understand that I have a right to revoke this authorization by sending written notification to the Tennessee State Athletic Commission, 500 James Robertson Parkway, Nashville, TN 37243. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for one year from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

Name (Print)

Signature

Date